(5) All current assessments in the database older than 110 days will be assigned the non-classifiable category of BC1 and given a default case mix index of the lowest index in the state.

(6) For purposes of calculating shadow rates, the department will use the RUG-III, 34 category, index maximizer model, version 5.12. The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

(7) For purposes of calculating shadow rates, case mix weights will be developed for each of the 34 RUG-III groupings. The department will compute a Montana specific case mix utilizing average nursing times from the 1991, 1995 and the 1997 HCFA case mix time study. The average minutes per day per resident will be adjusted by Montana specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information.

(8) For purposes of calculating shadow rates, the department shall assign each resident a RUG-III group calculated on the most current non-delinquent assessment available on the first day of the second month of each quarter as amended during the correction period. The RUG-III group will be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the department shall determine a simple facility average case mix index, carried to four decimal places, based on all resident case mix indices. For each quarter, the department shall calculate a medicaid average case mix index, carried to four decimal places, based on all residents for whom medicaid is reported as the per diem payor source any time during the 30 days prior to their current assessment.

(9) Facilities will be required to comply with the data submission requirements specified in this rule and ARM 37.40.321 during the rate year beginning July 1, 1999 for the development of a case mix reimbursement system. The department will utilize case mix data in the computation of quarterly shadow rates for the period July 1, 1999 through June 30, 2000. The department will compute shadow rates in order to determine what each nursing facility's rate would be established at if it was computed utilizing a facility wide case mix, a medicaid case mix index, or any other case mix methodology, as determined appropriate by the department. The shadow rates will be established for comparative purposes only. Facilities will be able to analyze this rate information during this time period in order to become more educated in its use as a reimbursement component for the transition to a case mix reimbursement methodology on July 1, 2000 or subsequent rule years. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.321 CORRECTION OF ERRONEOUS OR MISSING DATA

(1) The department will prepare and distribute resident listings to facilities on the first Friday of the second month of each quarter (cut off date). The listings will identify current assessments for residents in the nursing facility on the first day of the second month of each quarter as reflected in the database maintained by the department. The listings will identify resident social security numbers, names, assessment reference date, the calculated RUG-III . category and the payor source as reflected on the most recent full assessment as of the cut off date. Resident listings will be reviewed for completeness and accuracy. Resident listings shall be signed and returned to the department by the first Friday of the third month of the quarter. Facilities who do not return this corrected resident listing by the due date will use the database information on file in their case mix calculation.

(2) If data reported on the resident listings is in error or if there is missing data, facilities will have until the first Friday of the third month of each quarter to correct data submissions.

(a) Errors or missing data on the resident listings due to untimely submissions to the HCFA database maintained by the department of public health and human services (DPHHS) are corrected by transmitting the appropriate assessments or tracking documents to DPHHS in accordance with HCFA requirements.

(b) Errors in key field items are corrected following the HCFA key field specifications through DPHHS.

(c) Errors on the current payor source should be noted on the resident listings prior to signing and returning to DPHHS.
(History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489.)

37.40.322 OBRA COST REIMBURSEMENT (1) For rate years beginning on or after July 1, 1992, OBRA costs will be reimbursed under the per diem rate determined under ARM 37.40.307. No further reimbursement will be provided for such costs except as specifically provided in these rules.

(2) Each provider must document and submit to the department on a quarterly basis information on the nurse aide certification training and competency evaluation (testing) costs, including but not limited to the costs of training for nurse aides and the costs of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing). The required information must be submitted quarterly on the nurse aide certification/training and competency evaluation (testing) survey reporting form provided by the department and must include the total dollars incurred in each of the categories of facility personnel,

supplies and equipment, subcontracted services and testing fees. The reporting form must include a brief description of the items included in each of the four categories.

(a) Acceptable documentation will be any documentation that adequately supports the costs claimed on the reporting form and includes all records and documentation as defined in ARM 37.40.346, such as invoices, contracts, canceled checks and time cards. This documentation is subject to desk review and audit in accordance with ARM 37.40.346. This documentation must be maintained by the facility for 6 years, 3 months from the date the form is filed with the department or until any dispute or litigation regarding the costs supported by such documentation is finally resolved, whichever is later.

(b) If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346(4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.

(3) For periods beginning on or after April 1, 1992, medicaid nursing facility reimbursement for the costs associated with training and competency evaluation programs for nurse aides employed in medicare and medicaid nursing facilities, as required under the Omnibus Budget Reconciliation Act of 1987 (OBRA), shall be as follows:

(a) Nurse aide certification training and competency evaluation (testing) costs documented in accordance with (2) and allowable under ARM 37.40.345 will be reimbursed to the extent provided under the per diem rate determined under ARM 37.40.307. No further reimbursement will be provided for such costs.

(4) For purposes of reporting under (2), nurse aide tests are those tests which:

(a) demonstrate competency through testing methods which address each course requirement and include successful completion of both a written or oral examination and a demonstration of the skills required to perform the tasks required of a nurse aide;

(b) are performed at either a nursing facility which is currently in compliance with medicaid nursing facility participation requirements or at a regional testing site at regularly scheduled testing times;

(c) are administered to nurse aides actually employed by the facility; and

(d) do not exceed a third attempt by the individual nurse aide to successfully complete the portion of the test for which costs are reported. The written/oral examination and the skills demonstration may be taken separately if the nurse aide passed only one portion of the test in a previous exam.

(5) Competency evaluation (testing) costs reported by a provider shall include the testing entity's basic fee charged to the facility and other costs associated with competency testing, to the extent allowable under ARM 37.40.345. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

37.40.323 CALCULATED PROPERTY COST COMPONENT (1) This rule specifies the method used by the department to calculate the property cost component for a specific provider for rate years beginning on or after July 1, 1999. Such property cost component is expressed in dollars and cents per patient day.

(a) Nothing in this rule shall be construed to provide for an automatic rate increase on July 1 of a new rate year. A provider's rate in effect immediately prior to July 1 of a new rate year shall remain in effect throughout the new rate year and subsequent rate years except as provided in ARM 37.40.308.

(2) As used in this rule, the following definitions apply:

(a) "Base period" means the provider's cost reporting period from which property costs are determined for a given year.

(i) Except as otherwise specified in ARM 37.40.326, for rate years beginning on or after July 1, 1999, the base period is the provider's cost report period of at least 6 months with a fiscal year ending between January 1, 1998 and December 31, 1998 inclusive, if available or, if such a cost report has not been timely filed or is otherwise not available, the provider's cost report period of at least 6 months on file with the department before April 1 immediately preceding the rate year.

(b) "Property costs" means allowable patient-related costs for building depreciation, equipment depreciation, capital-related interest, building lease, and equipment leases, subject to the provisions of ARM 37.40.345. Property costs do not include insurance or tax costs.

(c) "Base year per diem property costs" means the provider's total allowable property costs divided by the number of provider's patient days for the base period.

(d) "Property rate cap" means the maximum calculated property cost component which the department will pay to a provider.

(i) For rate years beginning on or after July 1, 1996, the property rate cap is $11.50.

(e) "1999 property component" means the provider's calculated property component determined for rate year 1999 in accordance with ARM 37.40.323.

(i) For any provider providing nursing facility services in a facility constructed prior to June 30, 1982 and for whom a calculated property component has not been determined by the department in accordance with ARM 37.40.323 for rate year 1998, the 1998 property component shall equal the June 30, 1985 property rate computed for the facility according to the rules in effect as of June 30, 1985 and indexed forward to the 1992 rate year according to the rules in effect for rate year 1992.

(3) For rate years beginning on or after July 1, 1999, the provider's calculated property cost component is as follows:

(a) If the provider's 1999 property component is greater than the provider's base year per diem property costs, then the provider's calculated property cost component is the lesser of the provider's 1999 property component or the property rate cap of $11.50.

(b) If the provider's base year per diem property costs exceed the provider's 1999 property component by more than $1.86, then the provider's calculated property cost component is the lesser of the sum of the provider's 1999 property component plus $1.86, or the property rate cap of $11.50.

(c) If the provider's base year per diem property costs exceed the provider's 1999 property component by $1.86 or less, then the provider's calculated property cost component is the lesser of the provider's base year per diem property costs or the property rate cap of $11.50.

(4) Upon certification of newly constructed beds, a provider's calculated property cost component shall be adjusted to a property cost component calculated as follows:

(a) the adjusted component shall be the lesser of $11.50 or a blended rate determined by dividing the sum of the product of pre-construction square footage and the provider's July 1 calculated property cost component and the product of the additional constructed square footage and $11.50, by the total square footage after construction.

(5) Upon completion of an extensive remodeling, a provider's calculated property cost component shall be adjusted to a property cost component calculated as follows:

(a) the adjusted component shall be the lesser of $11.50 or the existing component plus a per diem amount determined by amortizing 80% of the amount derived by dividing the total allowable remodeling cost by the number of licensed beds after remodeling. Such amount shall be amortized over 360 months at 12% per annum. A per diem amount shall be determined by multiplying the monthly amortization amount by 12 months and dividing the result by 365. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD,

1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 1999 MAR p. 1393, Eff. 6/18/99.)

37.40.324 GRANDFATHERED PROPERTY COST COMPONENT (1) For rate years beginning on or after July 1, 1992, all grandfathered property cost components shall be eliminated and no provider shall be entitled to any grandfathering protection. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; TRANS, from SRS, 2000 MAR p. 489.)

37.40.325 CHANGE IN PROVIDER DEFINED (1) Except as provided in (2), a change in provider will be deemed to have occurred if the events described in any one of the following (1)(a) through (d) occurs:

(a) For sole proprietorship providers, a change in provider occurs where the entire sole proprietorship is sold to an unrelated party and a selling proprietor does not retain a right of control over the business.

(b) For partnership providers, a change in provider occurs where:

(i) a new partner acquires an interest in the partnership greater than 50%;

(ii) the new partner is not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest; and

(iii) the current or former partners from whom the new partner acquires an interest do not retain a right of control over the partnership arising from the transferred interest.

(c) For corporation providers, a change in provider occurs where stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated party.

(d) For all providers, a change in provider occurs where an unrelated party acquires:

(i) the provider's title or interest in the nursing facility or a leasehold interest in the nursing facility; and

(ii) the right to control and manage the business of the nursing facility.

(2) Regardless of the provisions of (1) through (1)(d), a change in provider will not be deemed to have occurred if the circumstances indicate that:

(a) a related party will acquire, retain or actually exercise substantial influence over the new entity; or

(b) the occurrence or transaction is undertaken primarily for the purpose of triggering a change in provider under this rule.

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party" means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity;

(ii) A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3)(b)(i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3)(b)(i); or

(iii) a sole proprietorship, partnership corporation or other entity in which a person described in (3)(b)(i) or (ii) has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal medicare law, regulation or policy or related caselaw regarding changes in ownership under the medicare program are not applicable.

(5) As required in ARM 37.40.306, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the medicaid program in accordance with applicable requirements. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.326 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) This rule specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least 6 months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in ARM 37.40.325.

(2) For in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least six months participation in the medicaid program:

(a) In a newly constructed facility or as a new provider not resulting from a change in provider as defined in ARM 37.40.325, the interim per diem rate shall be the bed-weighted median per diem rate for all nursing facility providers. The interim rate shall be determined based upon all non-interim provider rates determined by the department and effective as of July 1 of the rate year.

(b) As a new provider resulting from a change in provider as. defined in ARM 37.40.325, the new provider's interim rate will be determined in accordance with ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323, based upon the most recent medicaid cost report covering a period of at least six months as filed by the previous provider, and subject to any applicable minimum or maximum rate under the provisions of ARM 37.40.307(3) through (3)(c), as applied to the facility's average per diem rate in effect for the entire previous rate year, as if no change in provider had occurred.

(c) The provider's interim rate shall become effective on the date a provider begins providing medicaid services in a newly constructed facility, as a new provider or on the effective date of a change in provider as defined in ARM 37.40.325.

(d) For changes in provider occurring on or after July 1, 1993, the provider's interim rate shall remain in effect until the provider has filed with the department in accordance with ARM 37.40.346 a complete and accurate cost report covering a period of 6 months participation in the medicaid program in a newly constructed facility, as a new provider or following a change in provider as defined in ARM 37.40.325. Subject to (2)(d)(iv), the interim rate will be adjusted only upon computation of a new interim rate effective July 1 of each rate year, or following a rate adjustment request by a new provider with an interim rate set using a previous provider's cost report, as follows:

(i) if a new provider disagrees with the interim rate as determined using the previous provider's cost report, the new provider may request an adjustment of the interim rate in accordance with this section. The rate adjustment request must request an exception to the cost base and include an explanation and documentation with substantive evidence that demonstrates the new provider's costs are and/or will be sufficiently different than the previous provider's specific costs to warrant a rate adjustment in accordance with ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323;

(ii) acceptable documentation to substantiate a different cost base will include:

(A) a budget for operation of the nursing facility through the new provider's fiscal year end, including all cost centers as identified on the department's medicaid cost report worksheet A, with an explanation by cost center of why the costs will be different than the previous provider's; or

(B) actual costs incurred by the new provider to date and projected through the new provider's fiscal year end for all cost centers as identified on the department's medicaid cost report worksheet A, with an explanation by cost center of why the costs are different than the previous provider's;

(iii) the department will review the documentation submitted by the new provider and will prepare a proforma cost report utilizing the stepdown methodology of cost allocation to arrive at the allowable nursing facility costs. These costs will be considered as current costs of the rate year and as such no inflationary index will be applied. These costs will be used as the new basis for computing the interim rate in accordance with ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323, and the provider will receive a new interim rate based on such costs, regardless of whether such new interim rate is greater or less than the previous interim rate;

(iv) the new provider's interim rate shall be set as follows:

(A) if the previous provider's rate was less than or equal to the bed-weighted median rate for all facilities for the current year, then the new provider's interim rate shall be the lesser of:

(I) the previous provider's rate adjusted by an amount, if any, determined in accordance with (2)(d)(i) through (iii); or

(II) the bed-weighted median rate for all facilities for the current year.

(B) if the previous provider's rate was greater than the bed-weighted median rate for all providers for the current year, then the new provider's interim rate shall be the previous provider's rate.

(e) After the provider files a complete and accurate cost report as specified in (d), the department will determine a per diem rate based upon such cost report according to the provisions of ARM 37.40.307, 37.40.313, 37.40.314 and 37.40.323. Such per diem rate shall be determined using the period covered by the cost report as the provider's base period. The per diem rate determined in accordance with this subsection shall be effective retroactive to the date the interim rate set under (2) became effective. Any overpayment or underpayment shall be adjusted in accordance with the cost settlement rules specified in ARM 37.40.347.

(3) For purposes of calculating a per diem rate as provided in (2)(e), the following shall apply with respect to patient assessment scores used to calculate the direct nursing personnel cost component:

(a) For providers who have received an interim rate under the provisions of this section based upon a change in provider, the provider's direct nursing personnel cost component shall be calculated based upon the fiscal year 1999 average patient assessment score for the previous provider, as though no change in provider had occurred.

(b) For providers who have received an interim rate under the provisions of this section based upon provision of services in a new facility or as a new provider, the provider's direct nursing personnel

cost component shall be calculated based upon the fiscal year 1999 state wide average patient assessment score. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

Rules 27 through 29 reserved

37.40.330 SEPARATELY BILLABLE ITEMS (1) In addition to the amount payable under the provisions of ARM 37.40.307(1) or (5), the department will reimburse nursing facilities located in the state of Montana for the following separately billable items:

(a) colostomy set;
(b) ostomy face plate;
(c) ostomy skin barrier;
(d) ostomy liquid barrier;
(e) ostomy skin bond or cement;
(f) ostomy bag, disposable/closed;
(g) ostomy bag, reusable or drainable;
(h) ostomy belt;
(i) stoma wicks;
(j) tail closures;
(k) ostomy skin bond or cement, remover;
(l) ileostomy set;
(m) ileal bladder set;
(n) irrigation set for irrigation of ostomy;
(o) ostomy lubricant;
(p) ostomy rings;
(q) ostomy supplies not otherwise listed;
(r) ureterostomy set;
(s) ureterostomy supplies not otherwise listed;
(t) colon tube;
(u) disposable colostomy appliances and accessories;
(v) colostomy irrigation appliance;
(w) colostomy irrigation accessory;
(x) colostomy appliance, non-disposable;
(y) colostomy appliance;
(z) disposable ileostomy accessory;
(aa) disposable urostomy bags;
(ab) piston irrigation set;
(ac) blood or urine control strips or tablets;
(ad) dextrostick or glucose test strips;
(ae) implantable vascular access portal/catheter (venous arterial or peritoneal);
(af) indwelling catheter, foley type, two-way, teflon;
(ag) indwelling catheter, foley type, two-way, latex;